

2008 NURSING HOME DIVERSION MODERNIZATION GRANT
State Of Michigan – Office of Services to the Aging
Progress Report

Project Director

Bonnie Graham, Division Director, Quality Operations
Michigan Office of Services to the Aging
P.O. Box 30676
Lansing, Michigan 48909-8176
517.373.9360
GrahamBon@michigan.gov

Other Report Authors

Shirley K. Bentsen, Project Coordinator

General Grant Information

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AoA Program Officer: Greg Case

AoA Grants Management Specialist: Alexis Lynady

MICHIGAN OFFICE OF SERVICES TO THE AGING **REPORT NARRATIVE**

Year two of the NHD (CLP) grant allowed for program expansion from three participating Area Agencies on Aging to a total of 10 (of 16 AAAs). This report includes:

- a program report from each of the participating Area Agencies on Aging in two attachments – one containing information from the original three partners and another containing reports from six new partners
- this required program narrative, and,
- an attachment containing products produced during this reporting period.

A. What did you accomplish during this reporting period and how did these accomplishments help you reach your stated project goal(s) and objective(s)? Please note any significant project partners and their role in project activities.

Targeting

After several revisions to the targeting criteria, the following are currently in use:

- Lack of caregiver or limited caregiver support
- Late loss of bathing, dressing, bed mobility, mobility/wheeling and transferring and/or moderate to severe dementia
- Assets over \$2000
- Income of 300% of SSI or less (for Medicaid spend-down)

Participants

- # participants served: 281
- # Veterans served: 36

Participant Characteristics

- Average age – 83
- More than 75% report caregiver stress
- 46% of participants have late loss ADL's

MICHIGAN – Accomplishments, continued

- 46% of participants have dementia or are at cognitive risk (moderate to severe impairment on cognitive skills for daily decision-making)
- 33% are functionally eligible and with assets over \$50,000 and/or income greater than 300% of SSI (yellow risk category); 13% are functionally eligible with assets of \$25,000-50,000 and income less than 300% of SSI (orange risk category); 12% are at highest risk, being functionally eligible and with assets less than \$25,000 and income less than 300% of SSI (red risk category); 38% of people proved not to be functionally eligible to participate in the program
- 70% of participants are receiving Community Living Consultation; 26% are receiving Information & Assistance services only
- The most frequently used services used by participants are personal care, homemaking, respite, and home delivered meals
- 83% of participants remained in their home, 3% were transferred to a nursing home (all had dementia), 8% died, 1% entered the hospital, and there was a loss of contact with 5% of participants

Consumer Satisfaction

- 97% of participants are satisfied or very satisfied with the program
- 97% of participants would recommend the program to their friends or family
- 100% indicated they used the information they received to make decisions
- 100% indicated the information respected their values.
- 97% indicated the information was helpful.

Standards & Policies

Consensus was reached on a new service definition on “Community Living Supports.” This definition assists with implementation of self-direction, and bundles several functions/supports to provide a streamlined response and less burdensome reporting. Refer to Attachment A.

MICHIGAN – Accomplishments, continued

Information Technology

OSA and its project partners have identified data collection requirements and data elements. Data elements have been reviewed vis-à-vis the data collection system used by partners to make sure that all required elements are collected by local systems. Software on the state-level Aging Information System (AIS) is being upgraded to allow importation of CLP (NHD) data to the AIS, and a data export is being developed to submit data electronically to the state's AIS.

Training

All grant partners have participated in training on culture change related to person centered thinking/planning (PCT). Since the program's inception, 546 people have participated in training (150 in year one and 396 in year two). In preparation for these programs, 66 people have participated in focus groups to determine training needs (9 in year one and 57 in year two). Training participants have included care managers, Information and Assistance staff, and those serving in leadership/decision-making capacities. A breakdown of training type and number of people training is found in Attachment B.

B. What, if any, challenges did you face during this reporting period and what actions did you take to address these challenges? Please note in your response changes, if any, to your project goal(s), objective(s), or activities that were made as a result of challenges faced.

Training

There was some resistance to PCT training for care managers who felt they were already experienced in PCT. Initially the training was required for all care managers, and some of those who did not want to be in the training tended to influence the training atmosphere through their inattention and lack of participation. The requirement for participation was dropped, however an alternate strategy was put in

MICHIGAN – Challenges, continued

place. By reframing the invitation to participate in training and making it an honor, participants were selected based on their creativity, flexibility, ability to adapt to change well, and willingness to embrace new ideas and openness to learning. From a culture change perspective, this has the effect of bringing people together for training who are open and ready to learn. It also builds a corps of positive people who have had a joint positive learning experience, who are ready to adapt to agency change, and who can set the agency's agenda by demonstrating that change is here to stay.

Outreach

The Community Living Program (NHD) has grown over time, and the Community Living Consultants have become very busy in the original three partner sites. It's anticipated that the new sites will experience this same surge in request for assistance. Workgroups have been discussing how to meet expanding needs, and each site is developing its own response on how to handle success. This discussion comes at a time when there is a greater need for options counseling across all incomes and needs, while service dollars are contracting rather than expanding in Michigan's current economic climate.

One solution is to train and support I&A specialists to take on more options counseling functions with participants who have less intense needs. PCT training is offered to I&A specialists and the training can be adjusted for those who are engaged in counseling.

Targeting & Data Collection

Targeting criteria has changed over time and has necessitated revision of questions and forms. The initial intent was to have a special form completed for each participant in contact with the AAA. We learned from our specialists and experts, however, that everyone is inundated and overwhelmed with required data collection.

MICHIGAN – Challenges, continued

Sites may now either add targeting questions to their own intake/contact form, or use the form built for their use. Participant data is collected using the Michigan Choices Information System (MICIS) since AAA sites that are waiver agents already use the system to track waiver and care management participants. Fields have been added to collect information.

Name Change

The program's name change from Nursing Home Diversion (NHD) to Community Living Program (CLP) has caused some confusion related to program identity for our three original partners administering the program at the local level. Products printed with the original name, especially for marketing purposes, have to be reprinted with the new name and in doing so, financial resources have been wasted.

C. How have the activities conducted during this project period helped you to achieve the measurable outcomes identified in your project proposal?

Training

Over time, the training component has expanded and intensified as a result of data collection related to training needs, input from Area Agency staff, and recognition of organizational practice related to culture change. Training modules, for example, have evolved, having been influenced by lessons learned from data collected in support of training. The training cycle now contains several steps:

- Focus groups made up of representatives from the regions/Area Agencies to be trained to identify issues unique to that geographic area. Three focus groups are conducted, one each for I&A, care manager and leadership.
- Surveys based on PCT behaviors and beliefs, as well as organizational patterns, are distributed to each of the training groups to verify information collected in the focus groups.

MICHIGAN – Outcomes, continued

- Training is conducted; pre and post tests are administered the day(s) of training.
- A follow-up survey is administered to determine behavioral and belief change (to be conducted in the next two months).

Results of the pre- and post-tests and evaluations indicate that those trained demonstrate greater awareness of PC principles while working with program participants and staff in their organizations. Training participants also indicate that they value and appreciate the training.

Imminent Risk

Initial work on the project for year one was aimed at developing mechanisms to identify and recruit appropriate program participants. Imminent risk was loosely defined, aimed primarily at those with large assets and some articulated needs. Over time, and through experience of working with participants and reviewing data collected, targeting criteria was refined by identifying triggers for those at high risk for nursing home placement.

To date, four people have transitioned to a nursing facility; each had high needs.

- Three of the four have moderate to severe dementia
- All four have late loss ADLs
- All had limited caregiver capacity

D. What was produced during the reporting period and how have these products been disseminated? Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, and other informational resources. Include a copy of each project product.

MICHIGAN – Products, continued

Products from this reporting period are attachments to this report ~

A – Policy on Community Living Supports

B – Summary of training activities to date

C – Survey of I &A Specialists

D – Evaluation results of training for I & A staff

E – Consumer Satisfaction Survey results

Attachment A**In-Home Services for Community Living Program Grant Implementation**

SERVICE NAME	Community Living Supports
SERVICE NUMBER	B-12
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	<p>Promotion of an individual's reasonable participation within their local community by facilitating independence through provision of community living supports.</p> <p>Community Living Supports include:</p> <ul style="list-style-type: none">A. Assisting, reminding, cueing, observing, guiding and/or training in the following activities: 1) meal preparation, 2) laundry, 3) routine, seasonal, and heavy household care maintenance, 4) activities of daily living such as bathing, eating, dressing, personal hygiene, and 5) shopping for food and other necessities of daily living.B. Assistance, support and/or guidance with such activities as: 1) money management, 2) non-medical care (not requiring RN or MD intervention, 3) social participation, relationship maintenance, and building community connections to reduce personal isolation, 4) transportation from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence, 5) participation in regular community activities incidental to meeting the individual's community living preferences, 6) attendance at medical appointments, and 7) acquiring or procuring goods and services necessary for home and community living, in response to needs that cannot otherwise be met.C. Reminding, cueing, observing and/or monitoring of medication administration. <p>Note: social/emotional support of participant may be offered in conjunction with assistance provided.</p>
UNIT OF SERVICE	One hour spent performing Community Living Supports activities.

Minimum Standards For Agency Providers

1. Each program shall maintain linkages and develop referral protocols with each Independent Living Consultation (ILC), Case Coordination and Support (CCS), Care Management (CM), and MIChoice Waiver program operating in the project area.
2. All workers performing Community Living Supports services shall be competency-tested for each task to be performed. Completion of a certified nursing assistant (CNA) training course by each worker is strongly recommended.

3. Community Living Supports workers shall have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording client information. Additionally, skill, knowledge and/or experience with food preparation, safe food handling procedures, and identifying and reporting abuse and neglect are highly desirable.
4. Semi-annual in-service training is required for all community living supports workers. Required topics include safety, sanitation, emergency procedures, body mechanics, universal precautions, and household management.
5. Community Living Supports workers may perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care when individually trained by the supervising RN for each participant who requires such care. The supervising RN must assure each worker's confidence and competence in the performance of each task required.

Minimum Standards for Individuals Employed by Participants

1. Individuals employed by program participants to provide community living supports shall be at least 18 years of age and have the ability to communicate effectively, both orally and in writing, to follow instructions, and be in good standing with the law as validated by a criminal background check conducted by the area agency on aging that is shared with the participant. If providing transportation incidental to this service, the individual must possess a valid Michigan driver's license.
2. Individuals employed by program participants shall be trained in first aid, cardiopulmonary resuscitation, and in universal precautions and blood-borne pathogens. Training in cardiopulmonary resuscitation can be waived if providing services for a participant who has a "Do Not Resuscitate" (DNR) order.
3. Individuals providing Community Living Supports shall have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.
4. Individuals providing Community Living Supports shall be deemed capable, of performing the required tasks by the respective program participant.

Attachment B

NHD Trainings, Planning Meetings and Focus Groups Held

	FY 07/08		FY 08/09		Total	
Training Type	# of trainings	# of participants	# of trainings	# of participants	# of trainings	# of participants
Care Manager	0	0	8	233	8	233
Leadership	0	0	3	79	3	79
I and A	3	95	2	40	5	135
Collaborative Learning	1	55	2	44	3	99
Total Trainings	4	150	15	396	19	546
Focus Group Type	# of focus groups	# of participants	# of focus groups	# of participants	# of focus groups	# of participants
Care Manager	1	9	3	36	4	45
Leadership	0	0	2	23	2	23
I and A	0	0	1	7	1	7
Total Focus Groups	1	9	6	57	7	66
Planning Meetings	# of meetings		# of meetings		# of meetings	
Training/Outreach Workgroup Meetings	11		1		12	
Training Team Subgroup Meetings	19		6		25	
Internal Meetings (various)	7		0		7	
Total Planning Mtgs	37		7		44	

I&A Specialist Survey 2009

How many years have you worked with people who need I&A assistance?

	Frequency	Percent
Under 3 years	10	28
3-5 years	9	26.1
6-10 years	9	26.1
More than 10 years	7	20.3
	35	100.5

Under 3	8	23.2
3-5 years	11	30.8
6-10 years	9	26.1
more than 10 years	7	19.6
	35	99.7

How long have you worked with your present organization?

Under 3	19	53.2
3-10 years	10	29
More than 10 years	6	17.4
		99.6

Are you certified by the Alliance of Information and Referral Systems (AIRS)?

	Frequency	Percent	Valid Percent
No	12	32.4	34.3
Yes	23	62.2	65.7
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Do you have access to:

	Frequency	Percent	Valid Percent
A resource database	33	89.2	94.3
A good headset	28	75.7	82.4
A chair that can be adjusted	33	89.2	94.3
A workstation that can be ergonomically adjusted	23	62.2	65.7
Feel you can ask for what you need?	34	91.9	97.1

	Frequency	Percent	Valid Percent
No	1	2.7	2.9
Yes	34	91.9	97.1
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

	Frequency	Percent	Valid Percent
No	10	27	29.4
Yes	24	64.9	70.6
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

Do you feel pressure to:

	Feel Pressure to Complete		Receive Direct Feedback About Performance	
	Frequency	Percent	Frequency	Percent
Complete all the items on the form or screening tool?	16	45.7	20	54.1
Complete all forms neatly?	15	40.5	10	27
Spell things accurately and write in complete sentences?	15	40.5	8	23.5
Make the "right" referral to an outside agency?	35	94.6	18	52.9
Make the right referral to the Waiver	24	64.9	17	50
Make the "right" referral to the meals program	17	45.9	10	29.4
Make the "right" referral to the care management program	18	48.6	15	44.1
Complete calls within a designated time period	15	40.5	15	44.1
Limit the time on the phone with a consumer when other calls are waiting	13	35.1	11	32.4

Do you receive feedback indicating your performance:

My performance with recording information	28	75.7	82.4
My performance in talking with people	29	78.4	85.3
A consumer or family is doing better because of my work	17	45.9	50
I am part of a team	26	70.3	74.3

How often do you:

Complete assessments during the phone call with the consumer

	Frequency	Percent	Valid Percent
Always	8	21.6	24.2
Most of the Time	12	32.4	36.4
Never	5	13.5	15.2
Some of the Time	8	21.6	24.2
Total	33	89.2	100
Unanswered	4	10.8	
	37	100	

Ask all the required questions on the assessment form

	Frequency	Percent	Valid Percent
Always	12	32.4	36.4
Most of the Time	13	35.1	39.4
Never	5	13.5	15.2
Some of the Time	3	8.1	9.1
Total	33	89.2	100
Unanswered	4	10.8	
	37	100	

Mean 1.4

	Frequency	Percent	Valid Percent
1	28	75.7	82.4
2	4	10.8	11.8
3	1	2.7	2.9
7	1	2.7	2.9
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

Gathering all required information is my responsibility

Mean 1.6

	Frequency	Percent	Valid Percent
1	21	56.8	61.8
2	9	24.3	26.5
3	1	2.7	2.9
4	2	5.4	5.9
6	1	2.7	2.9
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

It is my responsibility to make sure they connect with the agencies I refer them to

Mean 4.3

	Frequency	Percent	Valid Percent
1	3	8.1	8.8
2	6	16.2	17.6
3	4	10.8	11.8
4	5	13.5	14.7
5	5	13.5	14.7
6	4	10.8	11.8
7	7	18.9	20.6
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

I'm responsible for the amount of money spent on services

Mean 6.3

	Frequency	Percent	Valid Percent
3	1	2.7	3
4	4	10.8	12.1
5	1	2.7	3
6	4	10.8	12.1
7	23	62.2	69.7

Total	33	89.2	100
Unanswered	4	10.8	
	37	100	

It is my responsibility to advocate for people

Mean 2.6

	Frequency	Percent	Valid Percent
1	11	29.7	31.4
2	9	24.3	25.7
3	7	18.9	20
4	4	10.8	11.4
5	1	2.7	2.9
6	2	5.4	5.7
7	1	2.7	2.9
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

It's my responsibility to provide the best information and support decision making

Mean 2.0

	Frequency	Percent	Valid Percent
1	18	48.6	54.5
2	8	21.6	24.2
3	3	8.1	9.1
4	1	2.7	3
6	2	5.4	6.1
7	1	2.7	3
Total	33	89.2	100
Unanswered	4	10.8	
	37	100	

It's my responsibility to keep people safe

Mean 3.4

	Frequency	Percent	Valid Percent
1	4	10.8	12.1
2	7	18.9	21.2
3	8	21.6	24.2
4	6	16.2	18.2
5	4	10.8	12.1
6	3	8.1	9.1
7	1	2.7	3
Total	33	89.2	100
Unanswered	4	10.8	
	37	100	

It is my responsibility to keep people out of a nursing home

Mean 4.4

	Frequency	Percent	Valid Percent
1	1	2.7	3.1
2	4	10.8	12.5
3	4	10.8	12.5
4	11	29.7	34.4
5	4	10.8	12.5
6	1	2.7	3.1
7	7	18.9	21.9
Total	32	86.5	100
Unanswered	5	13.5	
	37	100	

It is my responsibility to get all appropriate people referred to the waiver

Mean 2.8

	Frequency	Percent	Valid Percent
1	8	21.6	23.5
2	10	27	29.4
3	8	21.6	23.5

4	2	5.4	5.9
5	2	5.4	5.9
6	2	5.4	5.9
7	2	5.4	5.9
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

Who provides you with feedback on your work? (Feedback refers to how you completed a form or how you worked with a consumer.)

	Frequency	Percent	Valid Percent
Your direct supervisor	28	75.7	100
Other I&A specialists	13	35.1	100
Care managers	6	16.2	100
Referral sources outside your agency	7	18.9	100
Administration at your agency	5	13.5	100

Are you able to find out later what happened with consumers you work with? (For example, If they connected with a service they needed.)

	Frequency	Percent	Valid Percent
No	17	45.9	48.6
Yes	18	48.6	51.4
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

During your work week, How often to you:

Interact face-to-face with co-workers

	Frequency	Percent	Valid Percent
Almost Never	5	13.5	14.3
More than once a week	30	81.1	85.7
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Work with another professional inside your organization to help a consumer

	Frequency	Percent	Valid Percent
Almost Never	3	8.1	8.6
More than once a week	16	43.2	45.7
Once a month	5	13.5	14.3
Once a week	11	29.7	31.4
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Work with another professional outside your organization to help a consumer

	Frequency	Percent	Valid Percent
Almost Never	6	16.2	17.1
More than once a week	10	27	28.6
Once a month	9	24.3	25.7
Once a week	10	27	28.6
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Have meetings with your organization

	Frequency	Percent	Valid Percent
Almost Never	4	10.8	11.4
Once a month	20	54.1	57.1
Once a week	11	29.7	31.4
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Have case conferences about complicated cases

	Frequency	Percent	Valid Percent
Almost Never	18	48.6	51.4
More than once a week	7	18.9	20
Once a month	6	16.2	17.1
Once a week	4	10.8	11.4
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Do you have as much contact with your co-workers as you wish? (1= Too Little, 10 = Too much)

Mean 5.5	Frequency	Percent	Valid Percent
2	1	2.7	2.9
3	3	8.1	8.6
4	3	8.1	8.6
5	8	21.6	22.9
6	13	35.1	37.1
7	6	16.2	17.1
8	1	2.7	2.9
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Are your work hours...?

	Frequency	Percent	Valid Percent
flexible	16	43.2	45.7
structured	19	51.4	54.3
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

Do you receive comp time for working more than your normal number of work hours?

	Frequency	Percent	Valid Percent
No	14	37.8	41.2
Yes	20	54.1	58.8
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

**When there is a proposed change in grant funding, documenting casework, or reporting/information requirements:
I am solicited for my opinions by the state.**

	Frequency	Percent	Valid Percent
Somewhat Agree	3	8.1	8.8
Somewhat Disagree	8	21.6	23.5
Strongly Agree	1	2.7	2.9
Strongly Disagree	22	59.5	64.7
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

I am solicited for my opinions by my organization.

	Frequency	Percent	Valid Percent
Somewhat Agree	16	43.2	45.7
Somewhat Disagree	7	18.9	20
Strongly Agree	4	10.8	11.4
Strongly Disagree	8	21.6	22.9
Total	35	94.6	100
Unanswered	2	5.4	
	37	100	

I am included in a discussion of how changes will be implemented at my organization.

	Frequency	Percent	Valid Percent
Somewhat Agree	13	35.1	38.2
Somewhat Disagree	10	27	29.4
Strongly Agree	5	13.5	14.7
Strongly Disagree	6	16.2	17.6
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

I am able to develop my own process for completing the new requirement.

	Frequency	Percent	Valid Percent
Somewhat Agree	12	32.4	40
Somewhat Disagree	9	24.3	30
Strongly Agree	4	10.8	13.3
Strongly Disagree	5	13.5	16.7
Total	30	81.1	100
Unanswered	7	18.9	
	37	100	

Have you ever been involved in the development of policy at :

	Frequency	Percent	Valid Percent
Your department/division	22	59.5	100
Your organization	6	16.2	100
Community workgroup	0	0	
Regional workgroup	3	8.1	100
State workgroup organization such as Area Agency of Aging Association of Michigan	1	2.7	100

Management listens to me:

Mean 6.1

	Frequency	Percent	Valid Percent
1 Never	1	2.7	2.9
3	5	13.5	14.7
4	5	13.5	14.7
5	4	10.8	11.8
6	3	8.1	8.8
7	4	10.8	11.8
8	5	13.5	14.7
9	5	13.5	14.7
10 Always	2	5.4	5.9
Total	34	91.9	100
Unanswered	3	8.1	
	37	100	

What helps you adopt new procedures/behaviors/requirements at your job?

	Frequency	Percent	Valid Percent
Chocolate			
Administrative Support	8	21.6	100
Time to Adjust	20	54.1	100
Understanding Why Change is Being Made	19	51.4	100

Knowing Change Will Benefit Those I Work with

27 73 100

Training

22 59.5 100

25 67.6 100

Please rate your job satisfaction: (1=Not Satisfied, 10=Completely Satisfied)

Mean 7.7

Frequency	Percent	Valid Percent
1	2.7	2.9
1	2.7	2.9
2	5.4	5.7
5	13.5	14.3
4	10.8	11.4
8	21.6	22.9
11	29.7	31.4
3	8.1	8.6
35	94.6	100
2	5.4	
37	100	

How long to you plan to continue working as a I&A specialist?

Frequency	Percent	Valid Percent
3	8.1	8.8
5	13.5	14.7
11	29.7	32.4
15	40.5	44.1
34	91.9	100
3	8.1	
37	100	

Less than a year

1-3 years

More than 3 years

Indefinitely

Total

Unanswered

Mean 7.1	Frequency	Percent	Valid Percent
2	2	5.4	6.5
3	1	2.7	3.2
5	5	13.5	16.1
6	3	8.1	9.7
7	5	13.5	16.1
8	6	16.2	19.4
9	3	8.1	9.7
10	6	16.2	19.4
Total	31	83.8	100
Unanswered	6	16.2	
	37	100	

About how long would it take to train someone to do your job as an I&A specialist?

	Freq		
Under 3 Months	13	38.2	
3-6 months	15	44.1	
More than 6 months	6	17.6	
	34	100	

How would you rate your current skill level in using PCT? (1=Novice, 10=Expert)

Mean 6.8	Frequency	Percent	Valid Percent
1	1	2.7	3.1
5	4	10.8	12.5
6	6	16.2	18.8
7	9	24.3	28.1
8	9	24.3	28.1
9	3	8.1	9.4
Total	32	86.5	100
Unanswered	5	13.5	
	37	100	

	Frequency	Percent	Valid Percent
No	9	24.3	28.1
Yes	23	62.2	71.9
Total	32	86.5	100
Unanswered	5	13.5	
	37	100	

Does leadership/management have a plan for implementing PCT?

	Frequency	Percent	Valid Percent
No	10	27	34.5
Yes	19	51.4	65.5
Total	29	78.4	100
Unanswered	8	21.6	
	37	100	

Is leadership/management in your organization committed to PCT?

	Frequency	Percent	Valid Percent
No	10	27	34.5
Yes	19	51.4	65.5
Total	29	78.4	100
Unanswered	8	21.6	
	37	100	

Do you think that good person centered planning will ultimately save money....:

	Frequency	Percent
For the person receiving services?	2	7.1
For the family of the person receiving services?	3	10.7
For the state?	2	7.1

Attachment D

Evaluation of Person-Centered Training for I&A Specialists 2009

	N	Mean-Quality	Std Deviation-Quality	Mean-Usefulness	Std. Deviation-usefulness
Community living program	27	5.8889	0.69798	5.7143	0.76290
Mel's Diner	33	6.0000	1.17260	5.8182	1.23629
Understanding person centered thinking	33	6.0303	1.01504	6.0294	1.21818
Power and privilege	32	5.8750	1.18458	5.9688	1.20441
PCT and I&A	30	6.0667	0.78492	6.1935	0.87252
Menu for life	22	6.0000	0.92582	5.7500	1.29380
Triggering form for community living program	30	5.2667	1.31131	5.0645	1.71144
Learning circle	28	5.6429	1.09593	5.8214	1.05597

Trainers	31	8.8065	1.07763
Check In	28	8.8571	1.23871
The comfort of the site	31	7.9677	2.08940
The accessibility of the site	31	8.0323	2.18302
The food of the site	31	7.7742	2.09300
The parking	29	8.2414	1.97584

NHD Consumer Interview

Response Status: Completes

Filter: No filter applied

Oct 28, 2009 5:46 AM PST

3. Caller Type:

Consumer	9	27%
Proxy	24	73%
Total	33	100%

Interview Let's begin with some questions about the information you've received from [site name]. I am going to read several statements. I'd like you to tell me whether you strongly disagree, disagree, agree, or strongly agree with each statement. Do you have any questions before we begin? [Read each statement and all four response options. Do not read "don't know" or "NA" but use as appropriate.]

6. I received the information I wanted.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	22	61%
Strongly Agree	10	28%
Don't Know	1	3%
N/A	3	8%
Total	36	100%

7. The information I received was accurate.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	21	60%
Strongly Agree	9	26%
Don't Know	3	9%
N/A	2	6%
Total	35	100%

8. I learned about different options that are available to me.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	23	68%
Strongly Agree	7	21%
Don't Know	2	6%
N/A	2	6%
Total	34	100%

9. The information I received respected my values.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	17	49%
Strongly Agree	12	34%
Don't Know	4	11%
N/A	2	6%
Total	35	100%

10. The information was helpful.

Strongly Disagree	0	0%
Disagree	1	3%
Agree	19	54%
Strongly Agree	12	34%
Don't Know	1	3%
N/A	2	6%
Total	35	100%

11. The information was presented in a way that made sense.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	20	57%
Strongly Agree	11	31%
Don't Know	1	3%
N/A	2	6%
Total	35	100%

12. Services are available that will help me stay in my home.

Strongly Disagree	0	0%
Disagree	3	9%
Agree	19	54%
Strongly Agree	7	20%
Don't Know	2	6%
N/A	4	11%
Total	35	100%

13. I used the information I received to make decisions.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	22	63%
Strongly Agree	7	20%
Don't Know	2	6%
N/A	4	11%
Total	35	100%

14. Services are available that will meet my needs.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	18	51%
Strongly Agree	8	23%
Don't Know	2	6%
N/A	6	17%
Total	35	100%

15. I can get services I prefer.

Strongly Disagree	0	0%
Disagree	1	3%
Agree	22	63%
Strongly Agree	6	17%
Don't Know	2	6%
N/A	4	11%
Total	35	100%

16. I can have as much control over my services as I want.

Strongly Disagree	1	3%
Disagree	2	6%
Agree	18	55%
Strongly Agree	5	15%
Don't Know	3	9%
N/A	4	12%
Total	33	100%

17. (ILC Name) Discussed with me ways to pay for services.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	16	47%
Strongly Agree	6	18%
Don't Know	4	12%
N/A	7	21%
Total	34	100%

18. (ILC Name) Discussed with me how much Long Term Care services cost.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	19	58%
Strongly Agree	4	12%
Don't Know	4	12%
N/A	6	18%
Total	33	100%

19. (ILC Name) Discussed public programs that might be available to me.

Strongly Disagree	0	0%
Disagree	1	3%
Agree	17	49%
Strongly Agree	4	11%
Don't Know	4	11%
N/A	9	26%
Total	35	100%

20. (ILC Name) Discussed care I could receive in my home or from a nursing facility.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	24	69%
Strongly Agree	3	9%
Don't Know	1	3%
N/A	7	20%
Total	35	100%

Now I would like to talk with you about the assistance you received from your consultant [insert consultant name]. [Read each statement and all four response options. Do not read "don't know" or "NA" but use as appropriate.]

21. (My ILC) is knowledgeable.

Strongly Disagree	0	0%
Disagree	0	0%
Agree	18	49%
Strongly Agree	14	38%
Don't Know	1	3%
N/A	4	11%

Total	37	100%
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22. (My ILC) treats me with respect.

Strongly Disagree	2	5%
Disagree	1	3%
Agree	13	35%
Strongly Agree	17	46%
Don't Know	0	0%
N/A	4	11%
Total	37	100%

23. (My ILC) listens carefully to what I want.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	19	51%
Strongly Agree	14	38%
Don't Know	0	0%
N/A	3	8%
Total	37	100%

24. (My ILC) understands what I want.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	17	47%
Strongly Agree	13	36%
Don't Know	1	3%
N/A	4	11%
Total	36	100%

25. (My ILC) helps me learn how to work with family or volunteer assistance for my care needs.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	17	47%
Strongly Agree	6	17%
Don't Know	2	6%
N/A	10	28%
Total	36	100%

26. (My ILC) supports my choices.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	19	53%
Strongly Agree	12	33%
Don't Know	0	0%
N/A	4	11%
Total	36	100%

27. I trust (my ILC).

Strongly Disagree	2	6%
Disagree	0	0%
Agree	17	47%
Strongly Agree	14	39%
Don't Know	0	0%
N/A	3	8%
Total	36	100%

28. I am satisfied with the help I received from the Area Agency on Aging and (my ILC).

Strongly Disagree	1	3%
Disagree	0	0%
Agree	16	46%
Strongly Agree	13	37%
Don't Know	1	3%
N/A	4	11%
Total	35	100%

29. I would recommend this service to someone else who needed it.

Strongly Disagree	1	3%
Disagree	0	0%
Agree	17	47%
Strongly Agree	14	39%
Don't Know	1	3%
N/A	3	8%
Total	36	100%

30. Are the services or assistance you are receiving now helping you to stay in your current home?

Strongly Disagree	1	3%
Disagree	2	6%
Agree	15	42%
Strongly Agree	7	19%
Don't Know	0	0%
N/A	11	31%
Total	36	100%

31. What services or assistance are you receiving in your home now? Homemaker

Homemaker - Agency	4	25%
Homemaker - Paid Family or Friend	6	38%
Homemaker - Unpaid Family or Friend	6	38%

32. What services or assistance are you receiving in your home now? Housekeeping

Housekeeping - Agency	6	30%
Housekeeping - Paid Family or Friend	9	45%
Housekeeping - Unpaid Family or Friend	6	30%

33. What services or assistance are you receiving in your home now? Personal care

Personal care - Agency	6	43%
Personal care - Paid Family or Friend	4	29%
Personal care - Unpaid Family or Friend	5	36%

34. What services or assistance are you receiving in your home now? Home maintenance

Home maintenance - Agency	0	0%
Home maintenance - Paid Family or Friend	3	25%
Home maintenance - Unpaid Family or Friend	9	75%

35. What services or assistance are you receiving in your home now? Lawn care/snow shoveling

Lawn care/snow shoveling - Agency	4	25%
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Lawn care/snow shoveling - Paid Family or Friend	3	19%
Lawn care/snow shoveling - Unpaid Family or Friend	10	62%

36. What services or assistance are you receiving in your home now? Skilled nursing care

Skilled nursing care - Agency	4	100%
Skilled nursing care - Paid Family or Friend	0	0%
Skilled nursing care - Unpaid Family or Friend	0	0%

37. What services or assistance are you receiving in your home now? Nurses aide

Nurses aide - Agency	3	33%
Nurses aide - Paid Family or Friend	3	33%
Nurses aide - Unpaid Family or Friend	3	33%

38. What services or assistance are you receiving in your home now? Home delivered meals

Home delivered meals - Agency	7	88%
Home delivered meals - Paid Family or Friend	1	12%
Home delivered meals - Unpaid Family or Friend	0	0%

39. What services or assistance are you receiving in your home now? Transportation

Transportation - Agency	1	7%
Transportation - Paid Family or Friend	6	40%
Transportation - Unpaid Family or Friend	9	60%

40. What services or assistance are you receiving in your home now? Medication set ups

Medication set ups - Agency	1	11%
Medication set ups - Paid Family or Friend	2	22%
Medication set ups - Unpaid Family or Friend	6	67%

41. What services or assistance are you receiving in your home now? General care (undesigned)

General care (undesigned) - Agency	2	22%
General care (undesigned) - Paid Family or Friend	1	11%
General care (undesigned) - Unpaid Family or Friend	6	67%

42. Additional notes about home care services:

17 Responses

43. If we have additional questions, may we call you again in the future?

Yes	30	97%
No	1	3%
Total	31	100%

44. What was most helpful to you about the consulting service?

19 Responses

45. What would you change or add to the consulting service?

3 Responses

46. Is there anything else you would like to tell us?

16 Responses

47. Is there anything you need now?

15 Responses

48. Interview End Time:

33 Responses

49. Interviewer Notes:

19 Responses

AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT (10-12-09)
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

A. Agency Name: Area Agency on Aging 1-B

Participation in: (check one) X NHD 1 & 2 NHD 2 only

B. Accomplishments from the **start of your program to the present:**

- # of potential NHD participants identified: 542
- # of NHD participants enrolled in program: 90
- # of NHD participants self directing their care: 6
- # Veterans served through Veterans Program: 12 referred/10 enrolled

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.

The AAA 1-B had set aside up to \$50,000 of Title IIIB funds for purchasing service to NHD/CLP enrollees.

- Indicate amount spent by funding source.
\$29,663 was spent on purchase of service for those enrolled in the NHD/CLP program; all funds from Title IIIB.

- List flexible service options being made available for NHD participants. List same for caregivers.

One family is in the process of hiring a roommate for their loved on, to provide free room and board in exchange for providing some care.

In the Ukranian Village Senior Apartments we have worked with a vendor agency to provide a full time worker to serve several participants. The scheduling of service provision has been worked out to the satisfaction of the participants, and the worker flexes her time between them, maximizing efficiency of tasks such as laundry, yet remaining person-centered in all aspects of care. The Building Coordinator has been an essential partner in the success of this approach.

- Describe changes in systems, policies, and processes that the agency as initiated to embed person-centered thinking/planning into agency culture.

Each member of our management/supervisory team read the book Managing Transitions, a book recommended by the presenters at the NHD Leadership Training we all attended in October 2008. The book focuses on using a person centered approach to change. Our "big change" item was the implementation of the Harmony Information System, a more comprehensive approach to our technology needs to support our goal of person-centeredness for all persons we serve. The book

helped us develop a strategy for this change and continues to be a resource as we move through our “chaos” period, that period of time when we are no longer doing business the “old” way, and are learning how to do business the “new” way.

The move to the Harmony Information System necessitated the need to review and update all policies and procedures as they relate to Care Management, Intake, I&A, Network Development, and our Fiscal/Billing processes. During this review and update we are incorporating a person-centered language and approach throughout.

We also introduced Person Centered Thinking and service delivery to our vendor network. Further trainings with Care Managers and vendor partners are planned for fiscal year 2010.

We have been working with our Board of Directors on a strategic plan to guide the AAA 1-B for the next five years. Goal #4 of the plan is to “Increase capacity to expand/develop programs that deliver effective person-centered services tailored to a diverse and growing population”. Action items under this goal include the incorporation of best practices for person centeredness for all programs/services provided by the agency.

C. Indicate local project partners involved and the role they played in local NHD activities.

In Macomb County, the first county to partner with us on this project the following partners were involved:

- Macomb County Department of Senior Citizens Services – This agency houses our Resource Advocates, and they were instrumental in designing the local implementation of this program, and in bringing together the Community Focus Groups in Phase I of the project. Unfortunately, due to funding cuts at the County level, they lost staffing and were unable to maintain a high degree of involvement in the project the last half of fiscal year 2009. We are hopeful that the stabilization of funding in the county will allow them to be full partners in the years ahead.
- As part of our expansion of the NHD/CLP in fiscal year 2009 we reached out to HUD Building Coordinators to help us identify residents at risk of spending down to Medicaid and/or entering a nursing home. The three HUD Building Coordinators who chose to work with us are:
 - Ukrainian Village Senior Housing – The coordinator of this building was the most pro-active at identifying and referring potential candidates, and in fact became the most proficient and accurate at these referrals.
 - Clinton Place Senior Housing – The coordinator of this building struggled with the concept at first, but remains committed to the success of the project after seeing the outcomes for the tenants of the building.
 - Elizabeth Doles Manor – The coordinator of this building also struggled with the concept, and after working with her individually, retraining on the tools and process, she still referred no residents. Follow up investigation revealed that the demographic of this building was more suited to the MI Choice Medicaid Waiver program, as these residents did not have the assets that residents in other buildings had.
- Also in Macomb County outreach was completed to Senior Companions of Macomb, who have referred persons residing in the community to the NHD/CLP.

In Washtenaw County, the second county we worked with, outreach has been completed with the following agencies:

- Neighborhood Senior Services
- Jewish Family Services
- Catholic Social Services
- Silver Club Adult Day Center
- Washtenaw County Senior Nutrition Program

As a result of this outreach we have received many referrals for persons living in the community to the CLP/NHD project.

We also expanded our outreach to St. Clair County, by presenting this project to the Presbyterian Village in Fort Gratiot. They have expressed interest in working with us and we plan to fully implement NHD/CLP in this county in fiscal year 2010.

As part of Phase II of the NHD/CLP, we began working with two Veterans Administration Health Centers that service residents of the AAA 1-B region: the Ann Arbor VAHC and the Detroit VAHC. Each health center contact originally had different requirements for the referral and reporting processes; we have had conversations with both and they have agreed to look at the processes to streamline them going forward.

D. Indicate how consumers and caregivers have been involved in development of your program.

Our focus groups concluded and no meetings were held in this reporting period.

Both of our Community Living Consultants (formerly Independent Living Consultants) attended the T-Care training offered by OSA. They each worked with two caregivers as part of this training, and received tremendously positive comments from them. As we move forward with the project we hope to bring caregivers together to discuss outcomes and suggestions for improvements. We were unable to accomplish this goal during this reporting period.

E. List what was produced during the reporting period and how these products been disseminated
Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

There were several public outreach efforts in this reporting period. They are:

- Living Well Radio Spot: 30 second spot ran in June on WWJ AM
- Ask Your Neighbor radio show: Interview with Kathleen Kueppers in March
- Living Well Radio Spots: 30 second spots ran in September on WWJ AM, expanded to include additional radio stations: 93.1, 96.3, 98.7 and 100.4.
- We published a story in the February 2009 edition of the AAA 1-B *Access Newspaper*. This newspaper is distributed to 45,000 with 15,000 copies inserted in the *Oakland Press*.
- A training to the managers of our vendor providers was given in April 2009 Introduction to Person Centered Thinking and Person Centered Service Delivery. This presentation was well received by our providers and we are working on a training for their direct care staff. We chose to follow OSA's lead and involve the management and leadership component first to ensure buy-in to the concept before rolling this out to their other staff.

We continue outreach to the general public through our website, www.aaa1b.com. The verbiage was updated to remove “Nursing Home Diversion” and replace it with “Community Living Program”. The number of unique page views for the program and for introductory coupons varies monthly, but overall are increasing over time. Of the caregiver offerings, the Self Assessment has the highest number of views, followed by Strategies for caring for someone with Dementia.

F. Indicate challenges faced during this reporting period and actions taken to address them.

The name change, from Nursing Home Diversion to Community Living Program caused confusion, internally with AAA 1-B staff, as well as with our community partners and referring agencies. We do not have the funding to update the brochure at this time, due to the budget cut we sustained from OSA. Re-education has taken place for all stakeholders, and we hope to be able to reprint the brochure in the coming months.

The addition of the Veteran Directed Home and Community Based Service to the NHD/CLP project caused a dilution of attention to the original concept developed in Phase I, delaying our outreach plans to additional counties at the rate we had planned. We needed to place staff on the VD-HCBS program to develop forms and processes, attend planning meetings, and implement. We received twelve referrals from the two VA Health Centers that service region 1B, of which 10 were ultimately enrolled; two refused enrollment and one died a couple of days after our assessment, prior to implementation of services.

The Ann Arbor VA Health Center referred veterans who were very compromised, and already receiving a very high level of VA paid care, and paying privately in addition to what the VA was paying for. These veterans required a very high level of service, and the highest level of reimbursement agreed upon with the VA (based on LUPA rates in our region) was not enough to meet all of their needs. This required an adjustment of expectations on the part of the AAA 1-B staff, that the VA does not feel responsible for, nor expects to meet, all the needs of the veterans referred for this program. We had expected the VA program to run parallel to the MI Choice Medicaid Waiver program, including the self determination portion, but this proved to be an incorrect assumption. The Community Living Consultants worked diligently with the referred veterans and their caregivers to find community resources to augment service needs. Unfortunately, many community agencies have either closed or have long wait lists due to the economic climate in the State, impacting effective referrals and coordination to meet all identified needs.

The cost of implementing self determination in the VD-HCBS program is high the first month because of start-up costs. These include the cost of workman’s compensation insurance for each person employed by the veteran, as well as the initial set-up fees for the Fiscal Intermediary. These costs were surprising to the VA, and they were not willing to adjust the reimbursement level even for the first month. Consequently, only 2 veterans ultimately enrolled in self determination; several chose to remain with the provider the VA had been paying; those providers were in our DSP pool, and we were able to purchase more hours of service because we have negotiated lower rates with those vendors than the VA had. It was suggested to the VAHC’s that they consider a reimbursement model used by other States enrolled in the grant, reimbursing for fixed costs up front separately from the on-going service costs; they are unwilling to proceed with that model at this time, but are willing to discuss further.

The AAA 1-B is working to implement a second form of self determination called Agency of Choice. This model allows a program participant to have their preferred worker be hired by a specified agency and share responsibilities as a “co-employer” of sorts. The agency is the employer of record, handles hiring, workman’s compensation, payroll, applicable taxes and sets the pay rate for the worker; the participant is the supervising employer, creating the job description and supervising the employee while caring for them. This model is available with and without the involvement of a Fiscal Intermediary and the AAA 1-B is currently investigating this option and hopes to offer it to the VA and all NHD/CLP participants within the next few months.

As mentioned in the narrative in section C above, the economy affected the ability of the Macomb County Department of Senior Citizens Services to remain a full partner in this project.

Report Completed By: Kathleen Kueppers, Director of Community Support Services, AAA 1-B
Date: 10/19/09

AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT (10-12-09)
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

B. Agency Name: Tri-County Office on Aging, region 6

Participation in: (check one) X NHD 1 & 2 NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: 133
- # of NHD participants enrolled in program: 111
- # of NHD participants self directing their care: 111
- # Veterans served through Veterans Program: 0

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.
 - State 3B (202) 11,549.80
 - Merit-Tobacco Respite (992) 955.68
 - 3E Caregiver (204) 15,166.35
 - Total 27,671.83

- List flexible service options being made available for NHD participants. List same for caregivers.
 - At TCOA we offer all of our participants and their caregivers the option of choosing a home health agency that is contracted with TCOA and thus be eligible for a reduced rate.
 - We have offered to pay for personal emergency response systems if the participant pays for the other services they choose.
 - We have provided respite for families that have caregivers who continue to work.
 - We have offered to split the cost of hiring an aide for a short term so that participants can try the service.
 - We have helped to negotiate a bulk rate for participants who purchase either 24 hour care or all night care.
 - We have arranged for several home care agencies to be 'interviewed' by the participant/family in one afternoon with CLC present. This option is particularly popular with participants/families that have never used home care services.
 - Another popular request by participants/families is that CLC call several agencies to determine whether or not they have an aide that meets the participant's needs and has the attributes identified as important to the participant. Once 2-4 agencies have been located the information is usually turned over to the participant/family for them to pursue final choice.

- CLC at TCOA is co-trained as a Master Trainer for the Savvy Caregiver program. The two programs dovetail nicely to help support families/caregivers.
- Describe changes in systems, policies, and processes that the agency as initiated to embed person-centered thinking/planning into agency culture.
 - TCOA has long been committed to listening to consumers and valuing their expressed needs and desires. In 2005 TCOA was designated a Pioneer partner with MDCH Office of Long Term Care Supports and Services to develop self-determination. This model of service provision is consumers hiring, training and supervising their direct care workers (DCW). During this period trainings on person centered thinking (PCT) were provided. All TCOA Project Choices' staff and many others from the agency participated. The grant ended in March 2008.

The Tri-County Office on Aging embraces the philosophy of **Person-Centered Thinking**. In the past, Medicaid or other regulatory standards have governed the process of developing care plans for persons requiring long-term care. The **Person-Centered Thinking** philosophy recognizes that all participants are unique individuals with needs, wants, goals and dreams. Most people want the same things from life - an interesting and meaningful daily life; close relationships with others; opportunities to socialize and enjoy recreation, opportunities to develop talents and abilities; to be a part of and contribute to the community and feel valued and important. The **Person-Centered Approach** was designed to encourage people working with individuals in Long-Term Care situations to view the individual's needs through their eyes and to honor their preferences, choices and abilities. The benefits of the Person-Centered Approach include:

Individualized Planning Sessions

Increased respect of cultural preferences

Gathering together a group of committed allies who support you

A focus on what an individual can do, not what they can't do

Additional choices for our MI Choice/Project Choices participants –

Traditional service delivery or Self Determination

As the **Person-Centered approach** continues and builds on the strengths of our system health and safety are still top priorities. Also family involvement is essential. Although person-centered services are a new way of thinking it will be achieved within existing resources. It will not require new appropriations nor will it require a reduction in services now being provided. Person Center Services will not resolve all the difficulties an individual may face but it provides new tools and processes for achieving the results an individual and their family want.

PCT language stating TCOA's commitment has been included in agency brochures, on TCOA's web-site, and included in outreach presentations. The Advisory Council and Administrative Board members have also been provided information on PCT. TCOA's partnership with OSA through the Nursing Home Diversion (NHD) grant provided additional PCT training to Care Managers and initial training to other TCOA staff including Meals-On-Wheels, Information & Assistance (I&A), Outreach/Grants Manager and Administrative staff. TCOA's annual contractors; including I&A, legal, Long-Term Care Ombudsman; also participated in PCT training through this NHD.

- G. Indicate local project partners involved and the role they played in local NHD activities.
- a. TCOA has done extensive outreach into our community which has resulted in opportunities to educate and extend the public's knowledge of the NHD program. Some of these activities include (but are not inclusive of all):
 - i. A community presentation at a large apartment/condominium complex that houses a large percentage of seniors and children caring for the parents.
 - ii. Another example was the opportunity to be interviewed live on local radio station WLNS to discuss program.
 - iii. Partnering with OSA to participate in presentations at the 4AM conference last May.
 - iv. The CLC met with all of the Michigan owners of Right At Home (home care agency) to discuss NHD program and role of CLC's. Information was given to them re: their local AAA and a contact name and phone number if that region was an NHD partner.
 - v. Partnering with OSA to participate in trainings.
 - vi. Continued coordination of bi-monthly meetings for the CLC's to discuss issues and successes specific to our services. Discuss challenges and brainstorm possible solutions.
 - vii. Working closely with the local Meals on Wheels provider, who serves about 1200 meals each day to potentially eligible participants, to have their staff and volunteers understand the NHD program eligibility and goals.
 - viii. Partnering with local provider (Mareck Family and Geriatric Services) to again educate their staff about appropriate referrals.
 - ix. Ongoing contact with social work staff at area nursing homes.
- H. Indicate how consumers and caregivers have been involved in development of your program.
- a. Participants and their families have been and will continue to be key influences on the evolution of the NHD program. From the beginning this project has had the flexibility to "go forth and experiment" thus every interaction I have with participants and their supporters is geared towards trying new things, being open to new ideas, active listening, problem solving and continuously measuring the outcomes to provide a better quality and higher level of service. TCOA's goal for the NHD program (as with all of their programs) is focused on providing a greater range of choice and services/systems that significantly and positively impact the lives of our seniors.
 - b. TCOA has a consumer group, Quality=CSI (Choice, Satisfaction, Independence) that meets bi-monthly to give input on our services. CLC has been present at several meetings to discuss NHD program and ways to improve service.
- I. List what was produced during the reporting period and how these products been disseminated. Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.
- a. In partnership with other members of the Training/Outreach committee trainings specific to I&A, Care Managers and Leadership were developed and presented to all NHD

partners. TCOA's CLC actively participated in the NHD trainings held over the last six months.

- b. In partnership with other members of the Evaluation committee the Targeting form continues to evolve.
- c. The NHD program is posted on TCOA's website and is a source of many referrals. Seems to be very effective with out of town families looking for assist for their loved ones, see attached.
- d. A newsletter seen by all MOW's volunteers in an effort to increase their awareness of potential NHD referrals.
- e. The original Choices for Independence brochure is being updated.
- f. Participated in two presentations at the 4AM Conference: Person Centered I&A and Person Centered Capacities for Care Managers.
- g. A program specific care plan was developed along with a cover letter, see attached.
- h. An internal tier system has been developed to rank participants in the event that prioritizing becomes necessary, see attached.
- i. A program specific consent form has been developed, see attached.

J. Indicate challenges faced during this reporting period and actions taken to address them.

- a. A significant challenge has been the limited funds available to use to support NHD participants. It has had a positive effect in that we have become creative with the non-monetary supports and are developing ways in which the CLC can offer support in alternate ways (see list of flexible service options).
- b. Another significant challenge has been the almost explosive popularity of this new and unique service. It creates demands on our agency that were not fully anticipated yet affirms the value of the service. We have monthly meetings to address these concerns and work to remedy them.
- c. A slightly less significant challenge has been the renaming of the grant and the ever-evolving name for the staff person designated to be the CLC. It takes diligent review to keep resources updated with the correct information.

Report Completed By: Marcia Bondarenko, RN

Date: 10-19-09

AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT (10-12-09)
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

A. Agency Name: Area Agency on Aging of Western Michigan

Participation in: (check one) ☒ NHD 1 & 2 ☐ NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: _____
- # of NHD participants enrolled in program: 77
- # of NHD participants self directing their care: 77
- # Veterans served through Veterans Program: 12

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.
Local Care Management funding as well as agency reserves are used to support 39% of the full time Community Living Consultant position through March 2010. From April 2010 on the plan is to continue to fund the position using other agency resources. Resources available for direct service beyond the individuals private pay are not available. Funding has been cut and long waiting lists cannot be addressed. Unit rates have been negotiated with providers to reflect reduced AAA rates vs Private pay rates and made available to individuals and care givers. Individuals are also referred to other local resources.

- Indicate amount spent by funding source.

- List flexible service options being made available for NHD participants. List same for caregivers.

We currently offer both participants and caregivers a list of private pay providers for healthcare, meals, transportation, attorney services, financial services, (GT financial presently working on private pay agreement for bill paying service) podiatrists, counseling services and medical equipment.

- Describe changes in systems, policies, and processes that the agency as initiated to embed person-centered thinking/planning into agency culture.

Our consultant has a flexible schedule which allows her to offer consultations in the evenings to better accommodate the wishes of the participant and families. Also, a care manager and the consultant have undergone training for TCare (Dr. Rhonda Montgomery) which stresses and addresses the individual needs of primary caregivers. The organization has undergone a Strategic Alignment Survey with all staff to gauge the organizations ability to communicate effectively with staff and between staff. All documents and brochures have been revised to assure that they are consistent with health literacy guidelines and are easy to understand, clear and useful.

C. Indicate local project partners involved and the role they played in local NHD activities.

GT Financial has agreed to work on a program that serves the private pay participant in relation to bill paying and banking needs. Also, many of our homecare agency providers has agreed to accept a reduced rate for services rendered to Choices for Independence participants. The Caregiver Resource Network allows for outreach through their ongoing monthly meetings.

D. Indicate how consumers and caregivers have been involved in development of your program.

The needs of both consumers and caregivers are identified through the consultation process which helps in the development of the program (i.e. GT Financial is responding to our request to provide a private pay program for bill paying and banking needs based on the requests of our participants. Also, the use of TCare for the caregivers has allowed us to identify needs and desires of caregivers so that a more comprehensive resource list is developed and maintained.)

E. List what was produced during the reporting period and how these products been disseminated

Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

A new brochure has been developed using consumer friendly wording. Our website is in the process of adding the Choices for Independence program.

F. Indicate challenges faced during this reporting period and actions taken to address them.

The millage and Medicaid Waiver programs have very long waiting lists which has affected our ability to serve all those in need. In an effort to reach as many people as possible, the Choices for Independence program has been expanded to work with those people with very little or no assets who are still willing to consider using monthly income to help pay for services. Kent County Senior Millage funding has seen an overall reduction in revenue due to the local and state economic environment leading to a cut in the available funding for senior services across the board. Additionally OAA funded services have an extensive waiting list with an anticipated several month wait for service.

The Single Point of Entry pilots were de-funded resulting in an increase in requests for I&A and Options Counseling to the AAA, with no additional staffing resources.

Report Completed By: Julie Alicki, Suzanne Filby-Clark
Date: 10/21/09

AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT (10-12-09)
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

A. Agency Name: The Senior Alliance (TSA)

Participation in: (check one) _____ NHD 1 & 2 x NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: 22
- # of NHD participants enrolled in program: 5
- # of NHD participants self directing their care: 5
- # Veterans served through Veterans Program: 3

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.

TSA has dedicated funds to NHD-eligible individuals and caregivers; however, we are too early in the process of enrolling individuals to have utilized these funds. We expect to begin utilizing funds during the next reporting period.

- Indicate amount spent by funding source.

- List flexible service options being made available for NHD participants. List same for caregivers.

TSA and our partner, The Information Center (TIC), both offer extensive Information and Assistance services, ensuring that individuals and caregivers are aware of all service options. Options are also presented during Community Living Consultations. It is expected that many NHD participants will arrange and purchase their own services, which ensures that all services are completely self-directed. When dedicated funds are utilized to provide services, TSA ensures that individuals are aware that they have the right to choose the worker

providing the service. Many of our provider agencies routinely hire workers referred by participants, which allows the participant to find the worker of their choice and have that worker hired to provide their services.

TSA and TIC offer TCARE to caregivers. This program provides referrals, information and education to caregivers, supporting them in selecting the services that will best meet their needs.

- Describe changes in systems, policies, and processes that the agency has initiated to embed person-centered thinking/planning into agency culture.

TSA and TIC have participated in several training sessions about person centered thinking.

As a result of the sessions, TSA has implemented the following changes:

- Increased staffing in the Information and Assistance department;
- Limited the use of the overhead paging system to emergencies such as needing to evacuate the building;
- Reviewed equipment request process with staff to ensure that staff is taking responsibility for making management aware of equipment needs so that management can provide appropriate equipment;
- Educated the Advisory Council, Board of Directors, management and staff regarding person centered thinking;
- Incorporated person centered thinking into written policies and procedures for care managers;
- Incorporated person centered thinking as a meeting topic at several staff meetings;
- Scheduled monthly sessions for staff to meet with the Executive Director so they can make suggestions and voice concerns directly to him;

- Discussed person centered thinking with several vendors and begun planning a presentation on person centered thinking for all vendors;
- Revised questions and discussion topics for interviewing job applicants to ensure that any new staff will utilize person centered thinking.

C. Indicate local project partners involved and the role they played in local NHD activities.

TIC is TSA's primary local partner in NHD. TIC has participated in training and planning activities related to NHD and has screened and assessed participants. TIC has developed a NHD program that is offered to consumers who contact TIC. TIC also offers TCARE.

D. Indicate how consumers and caregivers have been involved in development of your program.

TSA has used consumer feedback in developing the program; however, this feedback has been minimal to date due to the limited number of participants in the program. We expect to continue to refine our policies and procedures as the program expands and we get additional feedback from consumers.

E. List what was produced during the reporting period and how these products been disseminated
Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

TSA and TIC both developed brochures for the program. These brochures are distributed at outreach events. TSA collaborated with the VA VISN 11 to develop a brochure for the Veteran's Program. TSA has also included information about NHD on its website and in the Seniority News, a local newsletter for seniors.

F. Indicate challenges faced during this reporting period and actions taken to address them.

TSA and TIC have both faced challenges in identifying appropriate consumers. Many potential consumers are reluctant to spend their own resources for care because they would prefer to utilize their resources in other ways or to not spend their resources at all. We have addressed these challenges by offering options that may be low or no cost in addition to providing information on options that would require the consumer to pay for service.

We have faced some challenges in getting the Veteran's Program established. It took longer than anticipated to get referrals from both the Detroit and Ann Arbor centers. We have enrolled one veteran through the Detroit center and are working with two veterans from the Ann Arbor center. We have been communicating closely with both centers and hope to enroll more veterans soon.

Report Completed By: Lydia Gold, Director of Operations
Date: October 15, 2009

AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT (10-12-09)
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

A. Agency Name: Area Agency on Aging, Region IIIA

Participation in: (check one) _____ NHD 1 & 2 xx NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: 16
- # of NHD participants enrolled in program: 9
- # of NHD participants self directing their care: 0
- # Veterans served through Veterans Program: 3

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.
- \$10,000 State funds
- Indicate amount spent by funding source.
 1. \$33.68
- List flexible service options being made available for NHD participants. List same for caregivers.
 1. Flexible service options have not been implemented for CLP clients at this time. We are still exploring how to utilize a fiscal intermediary (FI) when client does wish to pay for services provided by an individual (other than direct payment from client to caregiver). If the client is paying an individual privately, none of them have requested using an FI.
 2. Clients are all given a choice of vendor when seeking services through an agency.
 3. 2 of the 3 veterans are utilizing a combination of flexible service options (hired family and a friend) as well as agency support to supplement care.
 4. The 3rd veteran was previously receiving services by an agency not contracted with the VA or our AAA and we have since signed a contract with the agency to provide continuity of services for the veteran.

- Describe changes in systems, policies, and processes that the agency as initiated to embed person-centered thinking/planning into agency culture.

1. CLCs (Community Living Consultant) for all programs have flexible hours to accommodate the clients schedule and their needs.
2. CLC may not get all information on the initial assessment, but rather attempts to get information essential to set up services, meeting the client and caregiver where they are, and setting up time to evaluate or readdress other information later.
3. All intake is completed by the Information & Assistant Specialist.
4. CLC's do not have to complete each section of the assessment, but rather, only those pertinent to the client's desired outcomes and as allowed by the client.

C. Indicate local project partners involved and the role they played in local NHD activities.

1. All AAA3A vendors are actively referring potential clients for CLC consultation and potential service.
2. Waiver agents for Kalamazoo County (staff from Region IIIB and Senior Services) along with staff from the Disability Network Southwest Michigan participated in PCP training and are referring potential clients.
3. Staff is working with the local Veteran's Benefits Office and VAMC in Battle Creek to identify veterans who would benefit from in-home VA services.

D. Indicate how consumers and caregivers have been involved in development of your program.

1. Through PCP we have established a contract with an additional vendor. This vendor was providing services to a client who had previously been receiving services through an auto insurance claim which had run out.

E. List what was produced during the reporting period and how these products been disseminated
Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

1. Vendors have been informed of the CLP and VDHBS programs through regular provider meetings. The general community has been reached via news articles written for the AAA3A bi-monthly newsletter and the Senior Expo tabloid.

F. Indicate challenges faced during this reporting period and actions taken to address them.

1. Demographic information required to identify potential CLP clients needed to be included in the I & A forms. There was much discussion and many different templates recommended to obtain the information which became a bit confusing. Our I & A staff incorporated the required information into the I & A form that they are using. At the same time, there were other information system changes and staff changes that made this more of a challenge as the I & A staff became overwhelmed at times with the number of people calling for information, and the amount of information they were required to obtain. Because of other changes necessary to meet requirements of the AAA3A programs, we are again looking at how to streamline the process of information gathering/recording to more adequately accommodate the I & A specialists time.
2. Convincing consumers to use their own funds to purchase needed/desired services has also been a challenge. The CLC is working closely with the individuals in a person-centered manner to help them make that leap. We are purchasing services on a limited basis for a limited time when appropriate.
3. More veterans have been identified that would benefit from the VDHBS program, and vendors are hesitating to refer due to the limited enrollment. It has been difficult to convince vendor staff to continue to refer, even if it means the person will be put on a waiting list.

Report Completed By: Anne Zemlick

Date: 10/26/2009

**AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)**

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

B. Agency Name: Region 3B

Participation in: (check one) _____ NHD 1 & 2 X NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: _____13____
- # of NHD participants enrolled in program: _____3____
- # of NHD participants self directing their care: _____2____
- # Veterans served through Veterans Program: _____3____

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.

\$0 - Due to current program capacity and budget constraints, we are unable to do cost sharing with NHD-eligible individuals and caregivers at this time.

- Indicate amount spent by funding source.

\$17,237 – NHD-2 funds

- List flexible service options being made available for NHD participants. List same for caregivers.

Participants are offered the option of self directing their care. Both participants and caregivers receive guidance and counseling on effective ways to utilize their current financial resources to obtain in-home services and link up with other available community resources or funding sources.

- Describe changes in systems, policies, and processes that the agency as initiated to embed person-centered thinking/planning into agency culture.

Support Coordinators, the Leadership Team and I&A Specialists have participated in the OSA PCP training program. The Community Living Consultant and members of the Leadership Team have participated in NHD Work Groups.

- G. Indicate local project partners involved and the role they played in local NHD activities.

AAA-3B has collaborated with the Veterans Administration, community agencies, and local home-care providers to allow for access and provision of available support services. AAA-3B has utilized the agency's intake process and program waiting lists to identify and educate consumers, caregivers and other community agencies of the availability of the NHD program.

- H. Indicate how consumers and caregivers have been involved in development and implementation of your program.

Consumers and caregivers have been encouraged and empowered to participate in the development of the program by using a Person-Centered Planning approach, through face to face consultations and meetings, and enrollment in the Self-Directed care program.

- I. List what has been produced by the grant and how these products have been disseminated. Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

AAA-3B staff has developed NHD-2 a program brochure, fact sheets, resources guides, and administrative forms that have been provided to participants and their caregivers.

- J. Indicate challenges faced during this reporting period and actions taken to address them.

AAA-3B is actively working towards the continued advancement of the NHD Program by further compiling educational material and resources, meeting with the leadership team to develop program procedures, and brainstorming additional ways to identify potential participants and those in need of program assistance.

Report Completed By: Cristina McCullough
Date: 10/29/09

AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT (10-12-09)
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

C. Agency Name: Branch-St. Joseph Area Agency on Aging (3C)

Participation in: (check one) _____ NHD 1 & 2 __XX__ NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: __8__
- # of NHD participants enrolled in program: __5__
- # of NHD participants self directing their care: __4__
- # Veterans served through Veterans Program: __2__

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.
\$3,300 Title IIIB

- Indicate amount spent by funding source.
\$40.00 of title IIID has been used to purchase a PERS unit, with an expected amount of \$240.00 to be used during 09-10 to continue.

- List flexible service options being made available for NHD participants. List same for caregivers.

Evening/weekend service – for both participant/caregivers

“Rainy Day” fund

Fiduciary services available for those wishing to self-direct care

- Describe changes in systems, policies, and processes that the agency has initiated to embed person-centered thinking/planning into agency culture.

Revised our agency's Mission statement, instituted a Vision statement, and developed Value statements also.

K. Indicate local project partners involved and the role they played in local NHD activities.

Branch-Hillsdale-St. Joseph Community Health Agency – local match for grant funding, space, operational costs

L. Indicate how consumers and caregivers have been involved in development of your program.

Ongoing interaction with seniors and their caregivers in our area has allowed AAIIIC to assess and plan for the unique needs of those in rural areas.

M. List what was produced during the reporting period and how these products have been disseminated

Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

Article was written for Senior Times and will be published soon. Have disseminated fact sheets and pamphlets on VA program at community health fairs. CLC's and I&A staff attend various networking groups, allowing them to keep community partners updated and educated about the CLP.

- N. Indicate challenges faced during this reporting period and actions taken to address them. Cuts in VA funding have caused a waiting list for qualified veterans to participate in the Veterans Directed HCBC program. Both Community Living Consultants have been involved in the targeting and policy and procedure workgroups with OSA. This has allowed staff to remain up to date with current changes and philosophies of the Community Living Program.

Report Completed By: Kim Brown
Date: 10/26/09

D. Agency Name: Region IV Area Agency on Aging

Participation in: (check one) _____ NHD 1 & 2 XX NHD 2 only

B. Accomplishments from the start of your program to the present 10/1/2008-9/30/2009:

- # of potential NHD participants identified: 22
- # of NHD participants enrolled in program: 6
- # of NHD participants self directing their care: 3 – all Veterans
- # Veterans served through Veterans Program: 7

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.

Approximately \$2,000 from Title IIIB/TIIE was available since June 2009 through the end of the fiscal year, September 30th, 2009. No clients that were contacted by the Community Living Supports Consultant during this report period desired any home care services. The Michigan legislature is still debating a fiscal year 2010 budget, which covers October 1, 2009-September 30, 2010 and continued/further cuts to the Title IIIB program are expected. Once the extent of those budget reductions are known, Region IV will know what funds, if any, can be committed for services for the next reporting period for NHD program participants.

- Indicate amount spent by funding source.

\$0.00 – no money has been spent during this report period for in-home services for CLP clients.

- List flexible service options being made available for NHD participants. List same for caregivers.

Flexible options available to participants

Region IV Area Agency on Aging is prepared to offer any type of approved Care Coordination/Care Management services via a self-directed care option as well as introducing new blended services such as Community Living Support services to help people remain in their homes. A contract with a Fiscal Intermediary has been secured to help protect both the client/employer and their employee should a client choose to hire their own worker. One-time payments for goods and special services are also available. Vouchers for caregivers to purchase Respite Care are also available on other programs and could be made available to NHD participants if the need arises.

Flexible options available to caregivers

Options available to caregivers are a telephone or face-to-face consult with the CLS consultant. Consultations with caregivers can occur in Region IV AAA offices, at the caregiver's workplace, in a public setting, in the caregiver's home, in the care recipient's home, or at another location chosen by the caregiver. Caregivers also have full use of a Region IV community resource library, which lends material and/or provides copies of

material on a wide variety of programs, diseases, and helpful resource topics. Internet access is also available to caregivers via a computer in the library at the Region IV office. Information and Assistance specialists can also lend their expertise to caregivers. The CLS consultant connects caregivers with any known community resource or training event to meet the needs of the caregiver.

- Describe changes in systems, policies, and processes that the agency as initiated to embed person-centered thinking/planning into agency culture.

Region IV sent their leadership, Care Managers, and Information Specialists to person centered training through the PCT events. 100% of the I&A staff, and about half of the Care Managers have attended training, and 100% of the leadership of those teams, along with our CEO, has attended PCT training.

One Care Managers says she better understand what is important to her personally and knowing how to better take care of herself helps her be more person centered with her clients and colleagues. As she has identified her own needs, she can better help clients articulate what is important in their lives.

Management has become more aware of how to operate a person centered thinking organization. The CEO has regular meetings with the whole agency, providing updates on important projects, goals, current events, and future goals. Flextime policies in place at Region IV help to enforce that staffs' personal lives are important, and management is adaptable as staff as events occur and needs arise to be flexible with work arrangements.

Care Management leaders regularly ask for staff input. How do we make this form work better, is there a better process, what types of tasks are wasting your time? Many changes have occurred, both as a result of staff requesting a needed change, and likewise when a manager asks staff for input on a change idea. Some change ideas introduced by management were stopped when staff input was heard. Likewise, changes introduced by staff have been implemented. Customer Service is a core value held at Region IV Area Agency on Aging, recognizing both the outside clients as customers, and also recognizing our colleagues as internal customers.

The information and assistance (I&A) specialists changed their intake form and processes as a result of PCT. I&A lets the caller lead the discussion, rather than trying to collect all the demographic data first. If the conversation leads to referral for a program, I&A only collects the minimal amount of information necessary in order to process the application for that individual. Applicants may be referred to another program, another department, or another community resource to meet their needs.

As a result of the PCT training, Care Managers report they have learned to listen more. Placing a priority on asking the client when a good day, time, and place to meet; where to sit when entering the client's home. Care Managers list all the services the client is eligible for, and ask the client what services would be most helpful for the client. Management helps guide Care Managers to be fulfilling the needs of the client, not the needs of wants the Care

Manager thinks the client should be receiving, reinforcing that the client's wishes are at the center of what we do. Care Management Nurses and Social Workers are here to help the client fulfill their wishes, not to coerce the client to accept the ideas from the professional. Management helps staff embrace this philosophical shift in thinking. New staffs are taught this art of philosophy manner of service delivery during their training period, and seasoned staff help enforce it when paired with a newer Care Manager.

All Region IV managers have an open door policy. Staff report feeling free to approach management, introduce new ideas, and speak up when something is not working well.

A consumer advisory board as well as changes to the client survey will be implemented in the future to further garner feedback and input from those we are here to serve.

O. Indicate local project partners involved and the role they played in local NHD activities.

Care Management has worked with Information and Assistance staff to help explain the CLP program and purpose. I&A has sent referrals to the CLP consultant. Information about the CLP has been disseminated to housing complexes and housing managers in the area. CLP information has been disseminated to parish nurses. Both housing and the parish nurse, as a result of the information, have made referrals to the CLP consultant. Meetings with Veteran's Officers in Berrien and Cass Counties have occurred, to help disseminated information about all AAA programs, as well as highlighting the NHD/Veteran's Consumer Directed Services program. There is no county VA officer in Van Buren County so either Berrien or Cass County offices provide services to Van Buren Veterans as time allows.

Staff from the Battle Creek Veteran's Hospital presented an in-depth in-service to all Region IV Care Management staff and to Information & Assistance staff. For almost two hours VA staff discussed in detail programs and services available to Veterans, and how the VA system works. Lists of VA contact people were handed out, so Region IV staffs wanting to secure durable medical equipment for a Veteran, for instance, have a direct line at the VA to call to submit such a request.

P. Indicate how consumers and caregivers have been involved in development of your program.

Up until this point in the program, consumers and caregivers mainly have been care recipients of information and services. Region IV does have clients and older adults on both the agency Board of Directors and on the Advisory Council. A new client group is in the beginning stages of development at Region IV, and should be operating by the next reporting period.

A specialized survey tool was sent to 100% of the Veteran's enrolled in the Veteran's Consumer Directed Services. Survey results were shared with Battle Creek Veteran's Affairs Medical Center.

Q. List what was produced during the reporting period and how these products been disseminated
Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

- Administration on Aging testified about the Veteran's Consumer Directed Services program to U.S. Congress in May 2009.
- Representatives from the U.S. Department of Veteran Affairs testified about the Veteran's Consumer Directed Services program in June 2009 to a U.S. Congress House Committee.
 - An article describing this VA testimony and the Veteran's Consumer Directed Services appeared in the Region IV AAA Newsletter in June 2009. This newsletter is distributed to all staff, Board Members, and Advisory Council members at Region IV.
- Region IV presented on the Veteran's Consumer Directed Services program at the National Association of Area Agency on Aging Conference & Tradeshow held Minnesota 7/19/09-7/22/09.
- A local newspaper published an in-depth article about one Veteran enrolled in the Veteran's Consumer Directed Services program on the front page, top of the fold.
 - This article generated many phone calls and walk-ins inquiring about services for Veterans.
 - That article was the highlighted program nationwide throughout the Veteran's Affairs offices, hospitals, and medical centers.
 - The article was also noted in the nationwide ADRC Technical Assistance weekly e-mail.
- As a result of Region IV's heightened understanding of the Veteran's Affairs systems, a one-page sheet was developed noting the VA's three main programs – Burial Benefits, Benefits, and Health Care. This sheet was disseminated to all staff at Region IV Area Agency on Aging.
- A brochure about the Veteran's Consumer Directed Services program was developed in partnership with the five Area Agencies on Aging involved in the project with the Battle Creek VA Medical Center. These brochures were not widely distributed in Region IV as the program was not serving new Veteran applicants when the brochure was completed.
- A flyer adding the Veteran's Consumer Directed Services option was added by the VA to show a full list of all home care options available to Veterans.

Attachments to this report include the above-referenced documents.

R. Indicate challenges faced during this reporting period and actions taken to address them.

Many meetings and trainings were attended by various Region IV Area Agency on Aging staffs with other NHD1, NHD2, and Office of Services to the Aging (OSA) staff. Region IV was unclear when to start contacting clients. OSA had assumed work was begun by AAA CLP staff persons, while Region IV was waiting for a green light or a directive to actually begin work. As a result of this unclear communication, direct client contact was delayed at Region IV AAA.

Despite the direction from Office of Services to the Aging staff, Region IV was unclear on the content of what the CLP personnel was to accomplish. Region IV CLP was provided contact information for other CLP participating in NHD1; that peer support helped to clarify what activities the CLP personnel was expected to accomplish.

For me personally, the information I learned in the leadership training had good content, but I left the leadership training unclear what the next steps should have been. Region IV was able to send about half of the Care Managers to the PCT training, but I am unclear if these sessions will be repeated in the future for additional staff to attend.

Region IV recently received information about the required reporting data the CLP staff is to collect on each NHD client. Clarification on this will help us successfully fulfill program expectations.

Spotty meetings hosted by OSA has been a challenge during this project. Workgroups were combined, and set dates for meetings were instituted by OSA. However, frequent cancellation of those meetings leaves me unclear whether to expect a meeting to occur. OSA has been notified of the effect on AAA staff.

Regular meetings lead by Battle Creek VA have occurred between the AAA partners and the VA, but OSA staff was not been involved in those sessions. This situation means much of the information discussed between the VABC and the AAAs is repeated during AAA/OSA meetings.

Future wishes:

Continued articulation from OSA about the project goals and our status overall is helpful, successes and challenges faced by NHD1 and NHD2 partners is wonderful when that information can be shared amongst the partners, explanation of the workgroups work/goals and how that integrates into the CLP consultant's day-to-day-activity or overall OSA project goals, and clear outlines of next steps for workgroups/CLP consultants/AAA staff is most helpful.

Report Completed By: Dawn Tyler, Care Manager Director
Date: 10/19/2009

**AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)**

- Report should be written for all audiences using simple language; define technical terms
- Use 12 pt. font size in Times New Roman; double-space text with 1" margins
- Please list each report section, followed by the agency's response

E. Agency Name: UPCAP Services, Inc./U.P. Area Agency on Aging
Participation in: (check one) _____ NHD 1 & 2 X NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: _____8_____
- # of NHD participants enrolled in program: _____0_____
- # of NHD participants self directing their care: _____0_____
- # Veterans served through Veterans Program: _____11_____

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.
\$21,700 – specifically OAA resources to be used for self determination purposes
- Indicate amount spent by funding source.
YTD: \$0
- List flexible service options being made available for NHD participants. List same for caregivers.
At present we have only identified potential program participant and have just begun discussing actual enrollment activities with staff.

- Describe changes in systems, policies, and processes that the agency as initiated to embed person-centered thinking/planning into agency culture.

All agency staff have participated in state-sponsored seminars on person-centered thinking. Current internal policies and procedures are being examined to determine whether changes need to be made to foster a more person-focused approach

S. Indicate local project partners involved and the role they played in local NHD activities.
The Superior Alliance for Independent Living (our local CIL) and the local service providers within the three county target area have been engaged in discussions about the project's goals and objectives and in their particular roles in making the project a success.

T. Indicate how consumers and caregivers have been involved in development and implementation of your program.
Participation to date has been limited to discussions about the project's goals and objectives with the AAA Advisory Council. Once consumer enrollment begins, consumers and caregivers will be engaged on a frequent basis for feedback and suggestions to make the process more user friendly and/or person focused.

- U. List what has been produced by the grant and how these products have been disseminated.
Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

N/A

- V. Indicate challenges faced during this reporting period and actions taken to address them.
Primary challenge to date has been identifying potential participants and in determining time requirements for program staff to implement the project.

Report Completed By: Mark Bomberg

Date: October 26, 2009

AREA AGENCY ON AGING SEMI-ANNUAL PROGRESS REPORT (10-12-09)
COMMUNITY LIVING PROGRAM (referred to as NHD for report purposes)

F. Agency Name: Region 14, Senior Resources

Participation in: (check one) NHD 1 & 2 X NHD 2 only

B. Accomplishments from the start of your program to the present:

- # of potential NHD participants identified: 47
- # of NHD participants enrolled in program: 24
- # of NHD participants self directing their care: 24
- # Veterans served through Veterans Program: 0

- Identify amount and source of funds dedicated to NHD-eligible individuals and caregivers.

No funds were spent directly on NHD-eligible individuals.

- Indicate amount spent by funding source.

No amount was spent.

- List flexible service options being made available for NHD participants. List same for caregivers.

Upon consultation participants and their families are given a list of different services that are available in the community. The consultant discusses what the different services are and the cost of these services. The consultant will coordinate any of these services at the participants' request. Services include; personal care, in-home counseling, homemaker, home-delivered meals, home repair/maintenance, errands, transportation, adult day services, friendly visitors, in-home assessment, safety checks, personal emergency response system, and caregiver classes.

- Describe changes in systems, policies, and processes that the agency has initiated to embed person-centered thinking/planning into agency culture.

Within the agency steps have been taken to help reduce workload for staff. Care managers can now download information into a "silo" reducing the amount of time that

they formally spent coming into the office to sync their information. Also, the information is now readily available in order for other staff to serve the participant more quickly. Care management meetings have been reduced to once a month to help balance the cut in hours that case managers recently took due to funding cuts therefore allowing them more time to complete their work. A new universal intake form was developed to reduce redundancy for intake staff. The issues with the phone system and reception are being evaluated for improvement so that people calling in (and walking in) can reach the appropriate person without being transferred numerous times or waiting for long periods of time. Care managers are now including a PACE program brochure in their initial packets for care management clients to educate them about options for services when and if they become Medicaid eligible.

W. Indicate local project partners involved and the role they played in local NHD activities.

Senior Resources is housed in Tanglewood which is a campus for four agencies that all are specific to aging services. Call-211, Agewell and the PACE program are all located within the Tanglewood building. Call-211 is contracted to provide I&A as well as referral to Senior Resources programs including NHD. Several Call staff attended training on Person Centered Thinking and was part of the collaborative workgroup. The PACE program is also a referral source for the program when individuals have contacted them that don't meet the financial criteria for Medicaid. The Centers for Independent Living have also been informed of the program and have made referrals of individuals that are not Medicaid eligible.

X. Indicate how consumers and caregivers have been involved in development of your program.

In working directly with the consumer and their families, feedback has been an important part of the development of the program. Learning the knowledge base of the general population and the information needs has been pivotal. Information sheets have been developed and tailored based on what consumers and their families have stated they need for information.

- Y. List what was produced during the reporting period and how these products been disseminated Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, etc.

A one sided brochure was created for the program and has been disseminated at the hospitals, over 200 doctors offices, at health fairs and to individuals at Tanglewood. Kim Bailey appeared on a local television show to explain services that are available. Kim also attended three health fairs to educate the public and health professionals about the program. Kim sent out emails to all local churches and was featured in the 60 seconds newsletter that is disseminated to over 700 professionals in the community. The Nursing Home Diversion program has been on the Senior Resources website with links to contact Kim directly.

- Z. Indicate challenges faced during this reporting period and actions taken to address them.

A constant challenge has been completing an assessment in order to track individuals. The amount of information needed to complete an assessment isn't necessary to serve the client and can be intrusive. Additionally, it does not track the numerous people that I have assisted where I never met the direct participant but only served the family through consultation. It is unfortunate that these individuals cannot be tracked as well as those

that an assessment has been completed. Internally, the individuals are tracked using our database so that if a return call is received there are notes regarding what information has already been given.

Report Completed By: Kim Bailey
Date: 10/15/09